Michigan League FOR Human Services

June 2009

SCHIP Reauthorization: A Quarter will buy Health Care Coverage for More Michigan Children

For just over 25 cents per dollar of health care coverage, Michigan has the opportunity to extend benefits to more children in Michigan. Policymakers can significantly ameliorate the devastation of a family losing a job, which usually also means losing health care coverage, by providing expanded health care coverage opportunities for the children of those who become unemployed, as well as other low-income residents.

The reauthorized State Children's Health Insurance Program (SCHIP) provides such an opportunity. With the federal government paying nearly $.75 of every $1.00 spent, for a small state investment, great benefit could result for Michigan's children, and potentially Michigan's economy as federal dollars flow into the state. The stated goal of the reauthorization legislation is to enroll more uninsured children in health care, and the federal government is providing most of the funding to reach that goal.

This children's health bill provides unprecedented opportunity to the state at the same time as the state is experiencing unprecedented economic woes, including the highest unemployment in 25 years. Included in the new law, effective April 1, 2009, is significant new funding and numerous options to increase eligibility and improve children's health.

Background

The State Children's Health Insurance Program (SCHIP) was finally reauthorized in February 2009 after a protracted political fight. Political battles during 2007 resulted in two bills being passed by Congress and vetoed by President Bush. Override attempts were unsuccessful, and with Congress unable to reauthorize the program at that time, an 18-month extension, through March 2009, was approved and signed by President Bush. The extension bill included sufficient funding to cover projected shortfalls until reauthorization could again be considered.

In January 2009, the new Congress passed reauthorization legislation, called the Children's Health Insurance Program Reauthorization Act (CHIPRA), and in early February, President Obama signed the legislation into law.

This federal program is important to children's health in Michigan because it provides federal funds for the MIChild program, and in addition, until December 31, 2009, through a federal waiver, for the Adult Medical Program (also called the Adult Benefits Waiver). Both of these programs provide critical health care coverage to Michiganians who would otherwise be uninsured. More than 30,000 children and up to 62,000 adults receive critical heath care services with funding from this federal program.

1115 SOUTH PENNSYLVANIA AVENUE • SUITE 202 • LANSING, MICHIGAN 48912
517.487.5436/PHONE • 517.371.4546/FAX • WWW.MILHS.ORG
A UNITED WAY AGENCY

The State Children's Health Insurance Program was created by Congress in 1997 for a 10-year period. To continue, federal action was required before the end of fiscal year 2007. As indicated above, only an extension of the program, rather than full reauthorization, was accomplished at that time.

The program was initially designed to cover children in families whose income was too high to qualify for Medicaid, but had insufficient income to afford private coverage. In Michigan, the MIChild program was implemented statewide on September 1, 1998. To qualify for MIChild, a child must be ineligible for Medicaid, and have family income below 200 percent of the federal poverty level. The importance of this program to Michigan families is highlighted by national statistics that indicate only 19 percent of workers in families with children with incomes below 200 percent of the poverty level have employer-sponsored insurance coverage.

The legislation creating the program also permitted state waivers for alternative uses of the SCHIP funds for such purposes as covering parents, childless adults, or pregnant women. Michigan applied for a waiver, which was approved in January 2004 for five years, to cover childless adults.

Eligibility and Outreach

Under CHIPRA, states have the option to provide coverage to children in families with incomes up to 300 percent of the federal poverty level ($54,930 for a family of three in 2009) and receive the full federal matching rate. The reauthorization legislation extends the citizenship document requirement (applicants must prove citizenship) to SCHIP, effective October 2009, but allows a new electronic documentation option, for both Medicaid and SCHIP, with the Social Security Administration to reduce paperwork and barriers to enrollment. CHIPRA, however, reverses the Deficit Reduction Act of 2005 requirement that Medicaid cases not be opened until documentation is presented, and requires that benefits must be provided to otherwise eligible applicants while documentation is being pursued.

There are also several new options, with performance bonus payments for achievement, available to states to reach and enroll the lowest-income eligible children. States can use income information obtained from other sources (e.g., free and reduced price school lunch programs), information from other databases, or information from other federal programs without requiring a family to resubmit or reverify information. When using other sources, states must be able to distinguish between eligibility for SCHIP and Medicaid.

In Michigan, MIChild currently covers children under age 19 in families with incomes between 150 percent and 200 percent of the federal poverty level ($27,468 to $36,624 for a family of three). Children in families with incomes below 150 percent of the federal poverty level likely qualify for Healthy Kids, a component of Michigan's Medicaid program. Children are enrolled in MIChild for a 12-month period, after which families must reapply.

As of March 2009, there were about 32,000 children enrolled in MIChild. Historically, a majority of MIChild applicants have been determined eligible for Healthy Kids; in addition, the MIChild caseload began declining after outreach funding was eliminated in 2003.

The reauthorization legislation includes $100 million for grants to promote outreach and enrollment for SCHIP and Medicaid; $20 million is for specific activities, while $80 million is for

general grants to state (including government) and local agencies. These grants are 100 percent federal funding and do not require a state match.

For the adult component, the income limit is very low – 35 percent of the federal poverty level ($3,800 per year for an individual). Enrollment in this program is currently capped at 62,000, and as a result of the cap, enrollment has been closed much of the time since July 1, 2004. While the waiver was renewed in January 2009, the subsequent CHIPRA legislation specified that CHIP funds could be used for childless adults only through December 31, 2009. States can apply for Medicaid waivers to transition these individuals to Medicaid. Details of Michigan's plan/waiver proposal have not been released.

Services

SCHIP services are modeled after private coverage and require that "benchmark coverage" be provided. "Benchmark coverage" is defined as coverage that would be equivalent to that provided to federal employees by Blue Cross/Blue Shield, coverage provided to state employees, or coverage provided by the Health Maintenance Organization with the largest commercial enrollment in the state. SCHIP does not require the same broad coverage as is mandated under Medicaid.

While most states, including Michigan, provide dental coverage, it was not a mandated covered service in the initial legislation. Under CHIPRA, states must include dental benefits in their programs. In addition, CHIPRA also allows states to provide dental coverage to children who are enrolled in other coverage that does not include a dental benefit. To be eligible for this provision, a child must meet the eligibility criteria, other than being uninsured, for SCHIP. It is not yet known whether the state of Michigan will take advantage of this opportunity.

CHIPRA also requires mental health parity, that is, mental health services and benefits must be at the same level as physical health services and benefits.

The MIChild Program provides comprehensive coverage through managed care plans for a *family* premium of $10 per month (effective 4/1/07 the premium increased from $5 per month to $10 per month). MIChild benefits are provided through participating health plans, with the exception of mental health, substance abuse and dental services. Mental health services are provided by Community Mental Health Service Programs; substance abuse services are provided by the Substance Abuse Coordinating Agencies; and dental services are provided by Delta Dental, Blue Cross/Blue Shield, or Golden Dental. There are no dollar limits on medical services; there is a $600 per year per child maximum on dental services.

The adult program provides limited outpatient coverage to single residents or childless couples who do not qualify for Medicaid. Benefits are not provided through managed care organizations, rather some are provided through County Health Plans, while others are fee for service.

Other Provisions Included in Reauthorization

The reauthorization legislation also includes numerous provisions to improve health care services and outcomes for children enrolled in SCHIP and Medicaid. Included among them are:

- The development and dissemination of child-specific quality measures;
- Funding for demonstration projects to prevent childhood obesity, and to study quality measures and children's health information technology;
- Development of a model for children's electronic medical records; and

- Creation of a payment advisory council to review and make recommendations about payment rates for SCHIP and Medicaid services.

Financing

The reauthorization legislation adds significant new funding, $44 billion from April 1, 2009 – September 30, 2013, to continue coverage for enrolled children and to cover an estimated 9 million uninsured children nationwide. This increases the available funding over the above period to $69 billion; with the increase funded by a $.62 increase in the federal tobacco tax. CHIPRA also reduces the period from three years to two years that a state has to spend its annual allotment. After two years, unspent funds will be reallocated to states that demonstrate the need for additional funding. It is important to recall that SCHIP is a block grant (a specified amount is allocated to a state each year) and not an entitlement (federal government matches state spending with no limit).

SCHIP is a federal-state partnership with the federal government providing over 72 percent of the funding in Michigan and the state contributing less than 28 percent in FY2009. For fiscal years 2010 and 2011, the federal percentage is expected to increase to nearly 75 percent with the corresponding decrease in state spending to 25 percent. The federal share is limited to the state's allotment for the year, but for Michigan, a federal shortfall is unlikely considering both the substantial increase in allotment and the limitation on spending for childless adults. For FY2009, according to the Congressional Research Service, Michigan's allotment is projected to increase from the initial allotment (prior to reauthorization) of $146.2 million to $203.4 million. If Michigan continues its current MIChild policies, it is very likely that millions of federal dollars will accumulate unspent and be redistributed to other states.

Early in the program, Michigan accumulated a surplus of funds that, if not spent, would have reverted back to the federal government because of the high percentage of MIChild applicants who were eligible for Medicaid. To avoid the loss of federal funds and to provide health care services to more Michigan residents, the state requested a federal waiver to allow SCHIP funding to be used to provide a limited outpatient health care benefit to very low-income uninsured childless adults. This waiver, approved in January 2004 for a five-year period and renewed in January 2009, is extended only through December 31, 2009 under CHIPRA to provide limited health care coverage to up to 62,000 individuals who would otherwise be uninsured.

Options to Increase Health Care Coverage under CHIPRA

Michigan has numerous options to use, not lose, these federal funds for a very small state investment. As indicated above, under the new federal guidelines, Michigan could choose to increase the eligibility for MIChild to 300 percent of the federal poverty level; the state could increase coverage for pregnant women from the current 185 percent of the federal poverty level to the same income level as children (currently 200 percent of the federal poverty level); the state could provide dental coverage as a wrap-around benefit to otherwise eligible children who have coverage that does not include a dental benefit; the state could implement a premium assistance program for eligible children; or the state could eliminate the five-year waiting period for *legal* immigrant children and pregnant women who are otherwise eligible. Note: CHIPRA continues the ban on the use of federal funds for illegal immigrants.

Conclusion

If state matching funds can be identified to match the available federal funds, the state has a great opportunity to preserve and build on the high level of children's health care coverage that has long been a hallmark of Michigan. In a report released in March 2009 by Families USA, nearly 30 percent of the state's population under age 65 went without health insurance for all or part of the two-year period, 2007 and 2008. Of those uninsured, 1.17 million were individuals in families with incomes below 200 percent of the federal poverty level. A significant number of those individuals could be children who are eligible for MIChild. As a state, we cannot afford to compromise our children's health, increase the number of uninsured children, or impede their educational success by allowing increasing numbers of children to be uninsured.

PKc:2009 SCHIP Reauthorization.doc/jh